Response Statement
Washington State Board of Health Priority Work Agenda
from Laurie Garrett
June 2001

Introduction

The Washington State Board of Health (SBOH) asked Ms. Laurie Garrett to respond to its survey of priority work for fiscal years 2001 and 2002. Because of her knowledge and analysis of global public health systems, the Board thought it valuable to illicit her feedback on its work priorities and future direction. Ms. Garrett is the author of *The Coming Plague* and *Betrayal of Trust*, two well-documented accounts of emerging diseases and the public health infrastructure that is intended to manage the incursion of infectious disease. Currently a journalist with Newsday, her work has appeared in numerous publications. Ms. Garrett has been awarded the Peabody, the Polk (twice), and the Pulitzer for her stellar scientific reporting.

Ms. Garrett's responses to the Board's survey are included in this document. In an effort to be true to Ms. Garrett's words, her statements are presented in italics. Additional commentary or any clarifying text is presented in regular text form. She also provided references to her work that elaborate on points made in her response. Her references are included below with excerpts from her book, *Betrayal of Trust*. Additional information on Ms. Garrett can be found on her website: *http://www.lauriegarrett.com*

Response 1: The Process of Assessing Public Opinion

It strikes me that your process, as described above, may be your problem. Few Americans appreciate what, exactly, Departments of Public Health do on their behalf. They are not engaged. Public health is lumped together with all other government functions, and therefore is victim to the same antigovernmentalism and alienation that average Americans feel toward the Motor Vehicle Department and the IRS.

Before setting priorities, do you have an active means for assessing what your citizenry thinks about health? When I look at your list above it makes good sense from a standard public health perspective: any PhD candidate in public health who made a project of your state would probably come up with roughly the same list. But is it the list your citizenry would prioritize? Probably not. Surveys of American public opinion show very different concerns. Does that mean you should abandon the above, and switch to devoting the lion['s] share of your resources to pesticide screening of drinking water, analysis of GM foods and mad cow disease? No, I don't think so. But public health departments have to find ways to engage the citizenry, bringing its grassroots leaders into the process, or continue to suffer the slings and arrows of antigovernmentalism and social alienation.

Reference: *Interview with Laurie Garrett in Salon Magazine, July 2000*
http://www.salon.com/health/feature/2000/07/31/betrayaloftrust/index.html

In this interview, Ms. Garrett discusses the politics of public health practice. She elaborates on the historical divide between individual rights and community health. Relevant excerpts from this interview follow.

What was your motivation for writing this book at this particular moment in history?

After I finished "The Coming Plague," people were asking me, What's the solution? How can we avoid having these massive epidemics overwhelm us? And the obvious answer is, you need a tough public health infrastructure that can spot the incursion of infectious diseases in the early stages and take appropriate steps to stop it before it becomes the next AIDS pandemic.

Here in the United States, I realized that for the last, say, 10 years of my career, without consciously focusing on it, I had been chronicling the collapse of our public health system. And that one thing after another that had been occurring in our country was a direct result of the fact that we had severely eroded ... the very concept and the political power of public health.

What kind of events are we talking about?

In many states in the last decade, public health officials have tried to create such things as birth defect registries to track whether in some neighborhoods there's a higher rate of birth defects. And if so, might there be something responsible for it? This has been refused by one legislature after another as if it were some Big Brother intrusion.

Another example is attempts to create a notification system for immunization ... Many states were seeing that they were beginning to have resurgences of measles, resurgences of pertussis and other epidemics in children and thought, well, let's just make it easy on families. Let's create an immunization registration system. And then we can notify parents — your kid's now 2, and it's time for these shots. Virtually every time it's been brought up in any state, the legislature has said no way. They see it as some kind of government intrusion in private life.

That's one of the age-old questions of public health: How do you balance the individual's rights with the health of the community?

We didn't have any problem making those choices back when we had huge public health catastrophes all around us. In 1900, when waves of catastrophic epidemics would sweep through every city in this country, people didn't have a whole lot of problems with the idea that the government had a job, and that the job, among others, was to prevent epidemics and to stop these catastrophes from occurring.

When I travel around the world I rarely encounter this notion of individual rights vs. public health as a serious impediment to the ability of public health to do its job. It's a very American problem ... It's easy to be smug about it and to ignore the needs. The danger in a wealthy society is not as obvious as it was in your grandparents' day or as when as you get in an airplane and travel overseas.

When you're talking about the American health system, you make more of a distinction between public health and individual medical care than you do when you talk about other countries.

Because it's a clearer distinction in the U.S. We don't have a national healthcare system. In Sweden, medical care and public health are all government functions and usually through the same agencies, so the lines get more blurred. But in the United States, public health is really a government function, usually at a fairly local level, and medicine is ... an almost entirely private function, with some parts of it heavily government subsidized but in largely private facilities.

How is that bad for the health system?

We have given the bulk of health power to physicians and to organized medicine and most recently to the health management corporate structure, and we have allotted very little prestige and power to the practitioners of public health. They are paid far less; they are given dingy, lousy offices; and they're treated like lesser beings. They rarely succeed in beating the AMA [American Medical Association] or any organized medicine on any issue.

Several times we have come very close in this country to voting for some form of national healthcare. Each time, public health has been completely left out of the discussion. What are the things that increase life expectancy in America? What are the things that can make sure children do not die in America? That's never what we talk about ... We always start the debate from the wrong place, which is an assumption that everything that anybody wants that's called "medicine" should be paid for by government or not paid for by government.

Do you see any political will or emotional will on the part of Americans to change that system?

Yeah. When you ask the right questions, the surveys show that Americans are thinking with wisdom about this. It's simply that we've not had the debate start at the right point. If you start the debate from the point of who should pay for us to have absolutely everything we want done to us medically, you're going to lose.

We've ended up with a terrible system full of injustice that leaves no one satisfied except the very, very rich ... How can we pursue the sort of brave new world of medicine the Human Genome Project promises us and do so in a way that doesn't result in, say, 2 or 3 percent of the global population having access to this grand scheme? And 94 to 97 percent not only don't have access to this expensive medicine but actually lose access to older drugs that are no longer patentable but that used to protect them.

Reference: *Betrayal of Trust: Sections on Antigovernmentalism*

Ms. Garrett weaves the theme of antigovernmentalism throughout her book. However, chapter four gives special attention to this topic. She defines public health as *a bond—a trust—between a government and its people (558).* In impressive detail, she then

chronicles the history of public health in America from early colonial times to the present. She highlights the political idiosyncrasies, the social and cultural biases, and the economic forces that shape the local, state, and federal systems of government intended to protect and promote the public's health. Ms. Garrett describes many moments in U.S. history when the public's trust in government was lost. The Tuskegee experiments, the Vietnam War, the diethylstilbesterol (DES) disaster, and the government's handling of radiation exposure from the Cold War period are examples of this broken trust.

The society at large entrusts its government to oversee and protect the collective good health. And in return individuals agree to cooperate by providing tax monies, accepting vaccines, and abiding by the rules and guidelines laid out by government public health leaders. If either side betrays that trust the system collapses like a house of cards. (558)

To build trust there must be a sense of community. At the millennium much of humanity hungered for connectedness and community but lived isolated, even hostile, existences. Trust evaporated when Tutsis met Hutus, Serbs confronted Kosovars, African-Americans worked with white Americans or Estonians argued with Russians. (585)

…perhaps … Americans would grow fed up with their irrational public health and medical systems, demanding the long overdue, bold reappraisal of the a nation's priorities from the health of its people. By 2000 there were already organizations forming all over the United States, as well as internationally, demanding that the pharmaceutical and health insurance industries shift their priorities away, at least incrementally, from profits toward Humanity's most urgent public health needs. (584)

The Tuskegee Experiments

The credibility of the public health message was further undermined by racial stigma, as those diseases most prevalent in minority communities were commonly linked to African American, Native American, or Hispanic diets and behaviors. When the messenger was perceived as "white government" the message was viewed with suspicion, even hostility. The Tuskegee legacy haunted absolutely every public health effort aimed at black Americans during the 1990s. (559)

The travesty of Tuskegee would continue to fester in both the public health and African American communities, widening a credibility gap that was already vast. Eventually, the divide would become so great that in the 1990s all U.S. government public health pronouncements and programs would be viewed with hostility, even outright contempt, by African Americans of all social classes. (322)

The Vietnam War Period

Johnson was the chief victim of the so-called credibility gap between Washington and the people of the United States, but every member of Congress felt the sting of public mistrust and attack from many sides: the war in Vietnam…Despite passage of the Civil Rights Act life in African American urban ghettos only worsened, prompting explosive riots. And many white, working-class Americans fought militant battles to protect the jobs and lifestyles they felt were threatened by hippies and blacks. (342)

DES

After describing the United States' success in keeping thalidomide out of the U.S. market in the 1960s, Ms. Garrett describes the U.S.'s decision to accept the alternative diethylstilbesterol (DES) and its impact on the public's trust.

Women would find more cause to question the FDA during the 1970s as revelations mounted about … DES … Between 1958 and 1965 fully half of all pregnant women in the United States were given DES prescriptions. Following the 1962 thalidomide episode, the FDA decided to use its then-new powers to review the safety and efficacy of more than four thousand drugs it had already approved, including DES. Issued in 1967, the report found DES only "possibly effective" and "not harmful." (359)

Then in 1971 evidence began to mount of extremely rare vaginal cancers in young women whose mothers had taken DES while pregnant with them. The issue of "DES babies" was explosive… DES was used in livestock; it was fat-soluble and stayed in the animal and human body, causing ill effects, for years; high does of DES had been used experimentally on Michigan coeds as a "morning after" pill to prevent pregnancies. And through it all, the FDA took no action. It needed more data…By 1990 it would be estimated that some two million baby boomers had been exposed in utero to DES. By any measure, DES was a public health disaster, fueled by FDA inaction. "One cannot look back at the history of DES without being struck by the consistent and often flagrant failure of regulatory agencies –notably the FDA and USDA—to carry out their mandated responsibilities." (360)

Radiation

Ms. Garrett writes about government secrecy surrounding the nuclear testing in Alamogordo, New Mexico (324) and the Bikini Islands (334) and the later nuclear arms race.

It is clear from public records that are now available that the AEC [Atomic Energy Commission] *knew all along that any use of nuclear weapons would create a public health catastrophe. Nevertheless, in the name of national security the Eisenhower administration had veiled all radiation research conducted by the AEC and the Defense Department in secrecy and misinformation.* (335)

For the rest of the twentieth century, the American public would exhibit simultaneously both abject fear of all things radioactive … In the 1990s the Clinton administration would finally declassify many of the old AEC and Nuclear Regulatory Commission (NRC) documents, opening a window on ghastly human experiments, most of which were conducted by well-meaning civilian physicians, working in major U.S. teaching hospitals, who were largely oblivious to both the risks and ethical questionability of their actions…the public health radiation field would, at the close of the century, still be highly polarized and conflicted. (336)

Reference: *Jesse Ventura*

Describing Jesse Ventura's early days as governor of Minnesota, Ms. Garrett writes, *in making a distinction between the government and the people who elected it and whom it was supposed to serve, the Minnesota political leadership was reflecting a trend in American thinking that traced back to Goldwater. It wasn't antifederalism, however, but antigovernmentalism, fueled largely by the perception that Minnesota had become a welfare state for "them" – African Americans, Native Americans, immigrants, and poor "white trash" recently arrived from other states." (454)*

Response 2: Legitimate Community Involvement

If you could figure out a process for doing this [holding public forums] that drew the citizenry into it, legitimately, then this might be the better way to go. But it would be important for the people of Washington State to feel that their opinions were being heard. Does this sound threatening to the process? Sure. Groan. That's Democracy for you. But you must make a choice: generate another bureaucratic document that may or may not end up being relevant to your agencies' processes, or bring the populace into the process in a manner that leads to longstanding commitments, builds bridges and ultimately increases support for public health across the board. You will undoubtedly discover in the process a long list of unmet needs, roots of health alienation in minority communities and rural areas, a strong unchallenged thread of anti-science sentiments in your citizenry and severe class-based differences in both assessments of what constitutes "health" and access to it.

Reference: Interview with Laurie Garrett on *All Things Considered*, NPR, June 5, 2001
http://search.npr.org/cf/cmn/cmnpd01fm.cfm?PrgDate=06/05/2001&PrgID=2

On the occasion of the 20th anniversary of the official beginning of the AIDS epidemic, Linda Werthemier interviewed Laurie Garret about reporting with NPR in the early 1980s in San Francisco. She was one of the first science reporters following the epidemic, before people knew this disease was transmissible and when the medical community was baffled by the rising number of cases of unusual pneumonia, rare cancers, and suppressed immune systems.

She spoke to the difficulty of reporting on the AIDS epidemic in the early 1980s, the limited coverage given to the epidemic, and the implications that this silence had in protecting the public from infection. She attributes several factors to her difficulty in getting editors to realize the severity of the problem and allow its due coverage. In the early 1980s before the epidemic was well on its way, the death toll from AIDS was not apparent, causing some to deny its severity. At this same time, homophobia and a lack of willingness to use precise language (i.e., anal intercourse) undermined Ms. Garrett's ability to report in a manner that would protect those most at risk of contracting AIDS. It seems that she uses government's management of the AIDS epidemic as an example of the giant gap between the communities' perceptions, attitudes, and feelings about the virus and the government's fears and biases surrounding this "new" and emerging disease. Together, these conflicting attitudes would undermine public health's attempts to respond effectively to the epidemic.

The hardest thing as a journalist covering this epidemic has been maintaining objectivity. Sometimes it has been overwhelming… What keeps me going is a sense of rage. Ultimately, rage overwhelms my despair and I get angry and that gets me right back on the reporting beat …

Reference: Presentation by Laurie Garrett at NIH, May 31, 2001, *Beyond Betrayal of Trust: The Geopolitics of Getting from Lab to Global Clinic*
http://videocast.nih.gov/PastEvents.asp?c=4

In this distinguished lecture to the National Institute of Health, Laurie Garrett presents an exciting opportunity for Public Health to finally make its way into the global agenda of countries leaders, the United Nations, the World Bank, the International Monetary Fund, and other influential organizations. After describing the devastating conditions that people around the world are experiencing with HIV infection, hepatitis C, malaria, dysentery, TB, and antibiotic resistant strains of other diseases, she points out the need for an efficient public health infrastructure to address the many complex factors that interact to spread these diseases.

She described public health's reliance on the trust between government and its citizenry to ensure healthy air, water, and living conditions. She emphasized that public health is not medical care for the poor, as some often misconstrue. She points out the historical successes of public health interventions and the cost efficiency of these measures in comparison to the resource-intensive medical technology that has become ubiquitous in the American model of practicing medicine. She points to the ironic reuse of needles to implement universal vaccination programs and the parallel rise in HIV and hepatitis C cases, presumably from the reuse of nonsterile syringes. She challenged her audience to think about technically appropriate solutions to these global health problems, such as the creation of self-destructive hypodermic needles.

In this address, she speaks to the need for culturally appropriate interventions that truly meet the community needs.

Response 3: Collaboration

Here, again, engagement with the citizenry will reveal many such opportunities. Washington has a large Asian immigrant population, and it is my understanding that TB and several other diseases track in that population. It is well known that it is both easier and cheaper to deal with disease at its *source. Taking TB as an example, if health authorities reached out to the immigrant population, offering not only screening and treatment in the USA, but also to relatives overseas, the immigrant population might feel better served, and Washington might be better protected. How might Washington be involved in such a case overseas? Consider the example of* Public Health Research Institute (*PHRI) here in NYC, which uses its labs to track MDR-TB by genotype. When an unusual, highly drug resistant TB strain turned up in Russian immigrants in Brooklyn, PHRI genotyped those strains and matched them with strains in the Siberian area from which the immigrants came. They then notified collaborating health authorities in Russia, and* the *World Health Organization's TB office. This allowed the Russians to identify a hot spot of antibiotic misuse and inadequate TB treatment.*

With imagination and outreach health officials can undoubtedly identify dozens more possibilities. Diet might be another: Asians are particularly susceptible to alcoholism, diabetes, CVD and obesity when they switch from Asian to American diets. Second generation immigrants are the bridge. If health officials can focus on that second generation, helping them to take pride in their ethnic diets (when healthy), and to identify key danger foods in the "American" diet, this could build bridges.

Reference: *Betrayal of Trust: Sections on TB, immigrant transmission, global health threats, class disparity*

In *Betrayal of Trust*, Ms. Garrett describes the spread of TB, HIV, and other infectious diseases around the world. She points to the absence of effective collaboration between government and the citizenry necessary to adequately address these public health problems.

TB

Describing the TB epidemic in New York City in the late 1980s, she writes:

[B]*y 1989 some 88 percent of all TB patients treated at Harlem Hospital, for example disappeared before being cured. Those patients stopped their antibiotics as soon as they felt better, but before the bacteria were completely gone from their systems, thus allowing drug-resistant tuberculosis strains to emerge. When their illnesses returned, the patients came back for more antibiotics, and then again disappeared once they felt better. The cycle repeated over and over until at least a third of all active TB cases in New York City in 1990 were drug-resistant. (417)*

It was Czech scientist Karyl Stiblo's directly observed therapy (DOT) approach that was key: compelling patients not only to start multidrug therapy, but to stay on it for eighteen months until every last mycobacterium was cleared from their bodies. The health department in New York City hired squads of DOT workers who chased down a long list of TB patients, including the homeless, every day and watched to make sure they took their medicines. (419)

Before implementing DOT, which involved forcing patients to take drugs and isolating and restraining recalcitrant patients, Hamberg's [Director of New York City's Department of Health] *legal department had to thrash each measure out in the courts. Authority was eventually granted… By 1995, however, a total of 96 percent of all New York City TB patients would successfully undergo DOT… The trick after 1995 would be to maintain vigilance and a TB infrastructure, not only in New York but nationwide. (419)*

Ms. Garrett argues that by the end of the 20th century, TB offered *the most startling case of the failure of the medicalized model of public health. The catastrophic TB epidemic of Russia and neighboring formerly Soviet nations was out of control by 2000, despite considerable efforts to rein it in through the use of antibiotics. In 1997 and 1998 the World Health Organization stuck to its DOT mantra, repeating over and over that the region's governments should adopt the directly observed short course therapy approach to TB control. (575) But it didn't work. Drug-resistant TB swept over the Russian region, even in areas where authorities obediently followed WHO's protocols… DOT critics were uneasy. They argued that multidrug-resistant strains of TB had by 1999 emerged in more than one hundred countries, as the microbes stubbornly defied WHO's prescribed treatment. Further, most developing countries lacked a public health infrastructure that could effectively distribute the WHO-recommended drugs, especially to their poorest citizens. (576)*

In 1998, the World Health Organization brought together top pharmaceutical leaders, hoping to gain their support for development of some form of pill that, taken alone, would have the impact of the complicated schedule of multiple drugs that formed the basis of DOTS. If a sufficiently inexpensive formulation could be found, combining several drugs that were then make by competing companies, TB control would be far easier. But the meeting was a disappointment. The companies told WHO that their targets were $1 billion "big hitters" in the United States, not drugs that might sell for pennies in poor countries. There was no TB drug in the research pipelines of any major pharmaceutical or biotechnology company, anywhere in the world. The reason: no drug company was interested in pursuing any project that could realistically yield profits of less than $350 million a year, for five or more years. Even if all of the roughly estimated eight million TB sufferers worldwide went on the new super pill, each taking the medication for six months at an average total cost of eleven dollars per patient, the profit numbers simply wouldn't add up, the companies said. (577)

Immigrant Transmission

Ms. Garrett describes a history of discrimination experienced by immigrants in American. She elaborates on the lack of cooperation between government and these immigrant populations in addressing the spread of communicable diseases throughout the nineteenth and twentieth centuries. *The nations leaders feared that escalating waves of "filthy, dirty foreigners" arriving daily in New York harbor would import further epidemics. (294)*

In the mid-nineteenth century the U.S.-born population often saw immigrants as little more than sources of disease and filth, readily blaming them for all epidemics and, indeed, supporting sanitarian interventions that prejudicially targeted the newly arrived poor. Even when prejudice was not behind health departments' actions, political leaders could readily tap immigrant apprehensions, guiding the newly arrived Americans to see discrimination where it did not exist. Throughout the nineteenth century public health leaders tended, on balance, to side with the needs and biases of the native-born population. During the twentieth century the imbalance would persist, prompting federal officials to, for example, designate Haitian immigrants a "risk group for AIDS." And the same public health agencies would underplay issues that did preferentially afflict immigrants, such as the impact of pesticides on the health of Mexican farm workers, the remarkably high infant mortality rates seen in Latinos living in Los Angeles, and a plague outbreak among Chinese immigrants in San Francisco. Throughout the twentieth century, public health leaders would, with considerable difficulty, walk a fine line between the exigencies and suspicions of the immigrant communities and those of the native born. (290-291)

Global Health Threats

Throughout *Betrayal of Trust*, Ms. Garrett describes the presence and emergence of many public health crises around the world: including, plague in India, Ebola and HIV/AIDS in Sub-Saharan African, and radiation-related illnesses in Ukraine. In these cases and others, she speaks to the desperate need for global cooperation to address these devastating problems.

Referencing a 1998 IOM report on the catastrophic scale of antibiotic resistance, Ms. Garrett writes, *"the problem of antimicrobial resistance extends beyond science and public health into a domain of sizeable legal and regulatory challenge. Globalization has permitted microbes to move freely around the world, yet attempts to globalize a coherent public health response are constrained by national borders and concepts of sovereignty." (484)*

Class Disparity

Throughout chapter four, Ms. Garrett describes a history of poorer health status among poor and minorities communities. She highlights the way in which political, social, and economic biases have reinforced an atmosphere of racial and ethnic division and extreme

distrust. This distrust has repeatedly undermined attempts by well-meaning people to collaborate in the name of public health.

The legacy of the Tuskegee experiment would prove to be merely an extreme example of a larger failure for American public health. Throughout the twentieth century there would continue to be glaring differences in the life expectancies, health statuses, infant mortalities, and access to medical care for white versus nonwhite U.S. citizens. Public health leaders would, variously, prove ineffectual, apologist, blatantly racist, or simply determinedly ignorant in these matters. By the 1960s the divide between public health (both government and academic) and the nation's minority communities would be explosive. (322-323)

She describes the state of black America in the 1950s and 1960s. *Though the administrations of Eisenhower, Kennedy, and Johnson marked a time of remarkable prosperity and economic growth for the nation as a whole, more than half of the nation's black population lived in poverty throughout the 1950s and well into the 1960s. (338)* Quoting James Baldwin in 1961, she writes "to be Negro in this county and to be relatively conscious is to be in a rage all the time." (339)

On June 10, 1964, with bipartisan support, Johnson's Civil Rights Act of 1964 was passed by both houses. Title VI of the act eliminated all legal forms of racial discrimination in the practices of medicine and public health. In a harbinger of the way the battlefield would shift, Arizona senator Barry Goldwater expressed disgust with the act, signaling a new spin on civil rights adopted in a political atmosphere that had made overt supports of racial segregation political pariahs. The new tack for the extreme conservative wing of the Republican Party, then led by Goldwater, was to attack federal authority for imposing socially liberalizing laws. (340)

She writes of similar discrimination felt by the poor in Los Angeles. *Provisions of health services for the poor, even in times when most Los Angelinos were suffering, was considered "socialistic" by the county's elite, and they followed the Los Angeles Times's lead in denouncing alleged abuse of tax-supported services by the so-called undeserving poor.*

Reference: *Betrayal of Trust: section on individual rights vs. community responsibility*

Individual Rights versus Community Responsibility

One of the recurring themes in Ms. Garrett's work is the tension the American political process experiences between individual rights and community responsibility. This could not be more applicable than in the realm of public health. This tension magnifies the difficulty in realizing cooperation among individuals and government agencies charged with protecting public health. *As early as 1905, then, another critical and lasting theme of public health was emerging…the needs of the community versus the rights of individuals. (299)*

Where did we go wrong? Why had the sense of collective good disappeared? … One obvious answer –perhaps the answer—was the very success of the medicalized approach to public health. Antibiotics, vaccines, antivirals, pesticides, antiparasitic drugs—these had been triumphs when first introduced. And they had worked, pushing the microbes into retreat and allowing whole societies to relieve themselves of the collective burden of plagues and childhood deaths. For societies that had full access to these boons—these genuine scientific miracles—it was possible for individuals to shift their entire mind-sets from concern for the collective well-being to personal concerns about cancer, heart disease, diabetes, and countless other noncommunicable chronic ailments and killers. But the individualized and medicalized approaches no longer made sense by the close of the twentieth century, amid global travel, international economic trade, rising drug resistance, and a widening wealth gap. (579)

Ms. Garrett quotes Senator Hottinger from Minnesota on personal responsibility. *"Right now in Minnesota there's not a lot of sympathy for people who have needs. At least not in the sense of government. Personal responsibility is the watchword. We've used those words as excuses to forget about sharing and feeding the hungry…I have seen a big shift in the debate in Minnesota. The old tradition here of communalism isn't being well vocalized. The debate about government and public service is terribly one-sided. It's just, 'there's too much.' And no one vocalizes the value you get from government…*
The next time there's a meningitis epidemic in Minnesota and a couple of kids die and there aren't enough public health personnel to stop it quickly, then the public's view will change." (456)

Response 4: Global HIV/AIDS Struggle

Finally, you are fortunate in having Congressman. McDermott, an MD with a longstanding demonstrated concern about AIDS in the world. I am sure that bridges built through and with his office could lead to a long list of ways your Departments could play a role in the global HIV/AIDS struggle.

Reference: *Betrayal of Trust: sections on politics in public health, HIV in* the *U.S.*

Politics in Public Health

Ms. Garrett's references to political aspects of public health are far-reaching, touching every aspect of the discipline and every disease it attempts to control. She uses the case of HIV/AIDS to illustrate the political nature of disease management.

As the twenty-first century approached, the combined impact of mounting numbers of uninsured Americans, slashed public health budgets, and widespread antigovernment sentiment could be felt in the rundown county health offices, clogged public hospital emergency rooms, and mounting squabbles over which diseases were most deserving of federal research dollars. It made the job of public health an increasingly political one, forcing its advocates to defend not only their policies but also the role of government itself. (560)

HIV in the United States

Ms. Garrett has spent much of her career chronicling the HIV/AIDS pandemic. She has watched the world's attempts to mange the disease (with varying degrees of success). In parts of her book, she focuses on the political aspects of HIV/AIDS. She highlights successes when governments and communities have effectively collaborated. She also describes failures that have occurred when cooperation breaks down and distrust surfaces.

Ms. Garrett describes the successful influence that some community organizations have had on AIDS research. *In 1987, … most HIV patients did perish… for treatment was, at best, a crapshoot. (470)* Thanks to the work of many activist organizations, ACT UP, Gay Men's Health Crisis and others, *the pace of HIV science quickened in the 1990s… the new Highly Active Anti-Retroviral Therapy (HAART) brought the first genuine hope in the epidemic's grim history.*

A new test that *allowed researchers to tell who was recently infected with [HIV] versus who had been carrying HIV for years* revealed that *all of the newly infected San Franciscans were gay men, most of them white and in their thirties.* In an effort to learn more about these men Dr. Willi McFarland of the San Francisco Department of Public Health met strong opposition to *eliciting partner information from the state's mostly gay, male HIV population. "It raises a lot of issues—political things—and the memory of Typhoid Mary," McFarland said. "We were baffled by the tremendous resistance to naming names. Undermining our whole effort is community resistance." (475)*

These men *knew everything the CDC and groups like GMHC and the Stop AIDS Project had to say about HIV yet they rejected the prevention campaigns, calling public health officials and prominent gay leaders "safe sex police" and "condom police." They were "public health outlaws" and their popularity was rapidly increasing. (477)*

When public health officials reached out during the early 1990s to warn and educate the African-American community about the risks of HIV, they were stunned by the hostility and suspicion that greeted them. Tuskegee, the War on Drugs, racial hospital segregation—these legacies had built a mountain of resentment in the black community against organized medicine and government health authorities. Many African-American leaders declared HIV a racist conspiracy, claiming that the virus had been manufactured specifically to kill members of their race. Though prominent African-American public health leaders would try to counter these ideas, there was an overwhelming sense in the community that the soaring incidence of HIV in their ranks simply could not be a coincidence. It had to be deliberate. They had been victimized. (412)